
# Issue Briefs:
# Massachusetts
# Behavioral Health Analysis

**Veterans**

**Older Adults**

**Long Term, Home and**
**Community-Based Services and Supports**

**July 23, 2014**

# Veterans

Over the last decade, the United States has seen a dramatic rise in the recognition and understanding of post-traumatic stress, other traumatic brain injury and military sexual trauma and other related issues for returning US veterans. The nature of the wars in Iraq and Afghanistan combined with increased awareness of the neurological impact of trauma have created a surge in demand for trauma informed mental health and substance abuse treatment for veterans and others who experience trauma.

Over the last ten years, the demand and use of VA funded services has grown dramatically: by 80% for outpatient and 25% for inpatient services[1]. In a 2007 study, "25% of 103,788 veterans from Iraq and Afghanistan received 1 or more distinct mental health diagnoses. The single most common mental health diagnosis was PTSD…representing 52% of those receiving mental health diagnoses and 13% of all (the) veterans in (the study)". [2] In a similar, more recent study, 17% of Army and 12% of Marine service personnel reported a mental health problem according to a conservative definition, which involved a self-report of substantial functional impairment. Rates of PTSD using this strict definition were 12.2% - 12.9%.[3] These figures are more than twice as high as the general population. Substance use disorders are also a significant issue for people in the military. In the period 2004 to 2006, surveys found that an average of 7.1% of veterans aged 18 or older (an estimated 1.8 million persons) met the criteria for a substance use disorder in the past year.[4] Those who participated in active combat have a higher risk, as do those suffering from post-traumatic stress. A large national study of reserves and National Guardsmen deployed to Iraq or Afghanistan discovered rates of alcohol-related problems of 15.2% at baseline. Those who deployed and had exposure to combat had rates of new onset of such problems of 7.9%, significantly higher than the 4.8% rate of new onset among active duty personnel who were not deployed.[5]

Massachusetts Veterans generally have been reported to have good access to Medical Centers in Jamaica Plain, West Roxbury, Bedford, Brockton, and Leeds, as well as to the 15 outpatient clinic locations across the state. Massachusetts Veterans also have access to services provided by the Massachusetts Department of Veterans' Services.

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1 Department of Veterans Affairs, Veterans Health Administration, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning. (2000-2012). *Selected Veterans Health Administration Characteristics: FY2002 to FY2012.* Retrieved from http://www1.va.gov/vetdata/Utilization.asp.

2 Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S. & Marmar, C. (2007). Bringing the War Back Home: Mental Health Disorders Among 103 788 US Veterans Returning From Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities. *Arch Intern Med.* 167(5):476-482.

3 Hoge, C., et al. (2004). Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care. *N Engl J Med*, 351:13-22.

4 Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (November 1, 2007). *The NSDUH Report: Serious Psychological Distress and Substance Use Disorder among Veterans*. Rockville, MD. Accessed from http://www.samhsa.gov/data/2k7/veteransDual/veteransDual.htm on July 10, 2014.

5 Jacobson IG, Ryan MK, Hooper TI, et al. Alcohol Use and Alcohol-Related Problems Before and After Military Combat Deployment. *JAMA.* 2008;300(6):663-675. doi:10.1001/jama.300.6.663.

There are many examples of the valuable role that the state plays by helping to coordinate access to benefits for all people, including Veterans, with substance use disorders as well as mental health disorders. Several important examples follow.

The state funds advocacy and housing outreach for veterans through two programs: Statewide Advocacy for Veteran's Empowerment (SAVE) and Statewide Housing Advocacy Reintegration and Prevention (SHARP). The SAVE program is a collaboration between the Department of Public Health and the Department of Veterans' Services and has three office locations while operating with complete mobility for the Team members due to technology. The Outreach Coordinators seek to prevent suicide and reduce mental health distress by coordinating access to benefits and providing assistance with transition to civilian life. SHARP has thirteen peer specialists, a counselor, and a psychiatrist, as well as a 24/7 Warm Line and a housing specialist. SHARP Peer Specialists work collaboratively with SAVE and other agencies to connect Veterans to services. The Teams are now cross trained in housing assistance and suicide prevention.

Women Veterans are the fastest growing population of veterans in the Commonwealth. The Women Veterans' Network is a collaboration between the Massachusetts Department of Veterans' Services and other federal, state and non –profit agencies that works to inform women veterans' of their benefits as well as identify appropriate support services for the unique needs of women veterans.

Under Massachusetts General Law Chapter 115, each city and town has an appointed Veterans Services Officer (VSO) who helps to coordinate access to financial assistance benefits and other services, and assistance with accessing VA claims and other federal benefits. These include financial assistance to veterans and their dependents, access to housing services, employment services through the Boots to Business Career Mentoring program and the career centers as well as a full array of publicly supported mental health and substance abuse services.

The Department of Veterans' Services also has oversight of the two Soldiers' Homes in Massachusetts in Chelsea and Holyoke. Both of these homes provide domiciliary and transitional housing programs as well as long term care for veterans. The sites also serve as Veterans' services hubs with regular representation by SAVE, SHARP, Women Veterans' Network, Veterans' Services Officers, Veterans'; Organizations and Advocacy groups and legal services.

In addition to these services, The Department of Public Health's Bureau of Substance Abuse Services (BSAS) has a Coordinator of Veteran's Affairs dedicated to coordinating policy and access to substance abuse services for Veterans across different agencies, which has improved access to services for veterans across the Commonwealth. BSAS is also sponsoring workforce development activities that improve providers' understanding of military culture and its impact on substance use disorders.

The DMH Division of Forensic Services has been working with partner agencies, including state Veteran Services and the state medical school, to provide diversion activities focused on veterans based on a federal grant from SAMHSA. The grant funded the creation of a jail diversion and treatment model for male and female veterans of Operation Enduring Freedom/Operation Iraqi Freedom who are arrested for non-violent or low-level crime and who have PTSD or other trauma-related disorder and co-

occurring substance abuse. The program is currently in place in the Central and Western regions of the state. Veterans' Treatment Courts have now been established in Norfolk and Suffolk County with others in various stages of progress in Barnstable County and Middlesex County. The VALOR Act established guidelines to expand and study further treatment courts and the Trial Courts are looking at options to increase specialty courts to include additional Veterans' sessions.

The coordination of services is aided by data that is collected by Office of the Commissioner of Probation and the Commonwealth's Enterprise Service Management (ESM) Module. It will be important to use these data for further analysis of their needs for mental health and substance abuse services, housing and cash assistance, and how access to these and other services can be improved.

## Mental and Behavioral Healthcare of Older Adults

Nationally, as many as 20% of people 55 years or older have some type of mental health concern, including anxiety, severe cognitive impairment (dementia), depression, and bipolar disorder.[6] Roughly 3% of adults over the age of 50 in the US are coping with alcohol abuse and 0.3% with some form of drug dependence.[7] While rates for younger adults are higher for all disorders save dementia,[8] several exacerbating circumstances specific to older adults make behavioral health of particular concern, especially as the numbers of older residents grows.

Nationally, older adults are less likely to receive mental health services than younger adults.[9] Reasons for this include a shortage of trained geriatric mental health providers; lack of coordination among primary care, mental health, and aging services providers; and poor access to transportation.[10] Additionally, mental disorders are often missed by physicians treating older adults because of the preponderance and urgency of physical ailments associated with maturity.[11,12] Compounding the problems of missed diagnoses, mental disorders have a disproportionately adverse effect on the physical health of older adults. For example, untreated depression can exacerbate the effects of heart disease among older adults.[13]

The suicide rate among older adults is also higher than that of the general population, with the rate among non-Hispanic white men of 49.8 deaths per 100,000, which is over four times higher than the general population (all ages).[14]

Nationally, the number of older adults in need of substance abuse treatment is estimated to increase from 1.7 million in 2001 to 4.4 million in 2020.[15] Frequent alcohol use among older adults is associated with increased injury, illness, hospitalization, cognitive impairment, and mental illness.[16,17]

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[6] American Association of Geriatric Psychiatry (2008, June 23). Geriatrics and mental health—the facts. Retrieved from http://www.aagponline.org/prof/facts_mh.asp

[7] Blazer, D. and Wu, L. (2009, March). The epidemiology of substance use and disorders among middle aged and elderly community adults: National survey on drug use and health (NSDUH). *American Journal of Geriatric Psychiatry*, *17* (3), 237-245.

[8] Kessler, R. C., & Zhao, S. (2010). The prevalence of mental illness. Handbook of the Sociology of Mental Health: Social contexts, theories, and systems, 46-63.

[9] Karel, M. J., Gatz, M., & Smyer, M. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist, 67*, 184-198.

[10] Bartels, S. J., Blow, F. C., Brockmann, L. M., & Van Citters, A. D. (2005). Substance abuse and mental health care among older Americans: The state of the knowledge and future directions. *Rockville, MD: WESTAT.*

[11] National Alliance on Mental Illness (2009). Depression in older persons: Fact sheet. Retrieved from: http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88876

[12] American Psychological Association Office on Aging (2005). Psychology and aging: Addressing mental health needs of older adults. Retrieved from: http://www.apa.org/pi/aging/resources/guides/aging.pdf

[13] Ibid.

[14] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2006) Web-based Injury Statistics Query and Reporting System (WISQARS) Retrieved from: http://www.cdc.gov/ncipc/wisqars.

[15] Gfroerer, J., Penne, M., Pemberton, M., & Folsom, R. (2003). Substance abuse treatment need among older adults in 2020: The impact of the aging baby-boom cohort. *Drug and Alcohol Dependence*, *69* (2), 127-135.

[16] Dufour, M., and Fuller, R. K. (1995). Alcohol in the elderly. *Annual Review of Medicine*.

Based on expert opinion, there may be opportunities to strengthen behavioral health services provided to older adults:

- Services could be enhanced through coordination among providers specifically or disproportionately serving older adults, notably home care, primary and specialized care, first response systems, health literacy and information and referral services (e.g., SHINE Counselors), local councils on aging, and meal delivery. In addition, training for professionals in these organizations on behavioral health issues could be useful.
- Caregivers can help identify issues early on by paying special attention to stressful events or situations that affect the elderly, such as a disabling illness, loss of a spouse or loved one, retirement, or moving out of the family home.[18,19]
- Further health planning efforts could focus on identifying and documenting the availability of geriatric behavioral health specialists, including those who are able to provide specific treatment methods and interventions that have been shown to be effective in addressing depression substance abuse and stressors associated with aging.

[17] Adams, W L., et al. (1993). Alcohol-related hospitalizations of elderly people: Prevalence and geographic variation in the United States. *JAMA, 270* (10), 1222-1225.

[18] National Alliance on Mental Illness (2009). Depression in older persons: Fact sheet. Retrieved from: http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88876

[19] Adams, Wendy L., et al. (1993). Alcohol-related hospitalizations of elderly people: Prevalence and geographic variation in the United States." *JAMA 270* (10), 1222-1225.

# Long Term, Home and Community-based Services and Supports for Behavioral Health Consumers

Massachusetts' Community First Olmstead Plan reflects Massachusetts' on-going commitment to ensuring that people with disabilities and elders have access to community-living opportunities and supports that address each individual's diverse needs, abilities and backgrounds. Massachusetts supports the integration of a full array of home and community-based services (HCBS) for people with behavioral health conditions. The goal of Massachusetts' Community First initiative is to help health and human service consumers of all ages and levels of ability to live with dignity and independence in the community setting of their choice. HCBS services are funded as an alternative to institutional settings by Medicaid through a number of waiver and state plan options. Massachusetts' behavioral health system currently includes an array of home and community-based services that are primarily supported by state agency and MassHealth (Medicaid) funds.

The Massachusetts behavioral health system provides several cost-effective, evidence-based behavioral health interventions demonstrated to assist mental health consumers with recovery, to improve quality of life in a community setting, and to prevent repeat hospitalizations.[20,21,22] Peer support, [23] assertive community treatment,[24] targeted case management[25], supported employment[26] CBFS and Medicaid support through rehab option are important cornerstones for a home and community-based behavioral health system, and DMH funds these types of services for DMH clients with serious and disabling mental illness. The Bureau of Substance Abuse Services (BSAS) supports the Family Recovery Project facilitating comprehensive home-based services for families struggling with substance abuse and who are involved with the Department of Children and Families in two regions of the state.

A variety of other home and community-based services serve people who may have behavioral health conditions as well as physical health issues. State plan HCBS includes programs such as adult day health and day habilitation, and services including clinic services, therapeutic behavioral supports, and family and peer support. Most of these services have been

[20] Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16* (4), 11.

[21] Weisbrod, B. A., Test, M. A., & Stein, L. I. (1980). Alternative to mental hospital treatment: II. economic benefit-cost analysis. *Archives of General Psychiatry*, *37* (4), 400.

[22] Drake, R. E., et al. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, *52* (2), 179-182.

[23] Solomon, P. (2004). Op. Cit.

[24] Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment. *American Journal of Orthopsychiatry, 68* (2), 216-233.

[25] Mueser, K.T., et al. (1998). Models of community care for severe mental illness. *Schizophrenia Bulletin, 24* (1), 37-74.

[26] Bond, G. R., Becker, D. R., Drake, R. E., et al. (2001). Implementing supported employment as an evidenced-based practice. *Psychiatric Services*, *52*, 313-322.

oriented to people with a primary diagnosis of a mental or substance use disorder; however, Day Habilitation is for individuals with a diagnosis of Intellectual Disability. MassHealth also provides HCBS through its managed care programs that also offer behavioral health care integration: For adults age 21-64 through its OneCare Demonstration Project; for adults over age 55 through its Program of All-Inclusive Care for the Elderly (PACE), and/or for adults age 65 and over through its Senior Care Options (SCO) Program. There is increasing recognition of the behavioral needs of a much wider range of people who may also receive services such as occupational therapy, personal care attendants, and home health aides. Many of these other HCBS services are focused on restoring self-care skills needed for activities of daily living (ADL); they are often supplemented by supports like home modification and assistive technology.

Existing HCBS providers can indirectly contribute to the treatment of mental illness and substance use disorders by supporting adherence to medication regimens, nutrition, personal hygiene, and management of appointments. Providers of these services could potentially benefit from training to recognize and screen for behavioral health disorders, make referrals, and understand how to effectively communicate with people who may be suffering from a behavioral health condition. HCBS providers are in a unique position to identify and address behavioral health concerns before a full blown crisis ensues, and to assess living environment, social supports and other circumstances that affect consumers' ability to succeed in the community. HCBS providers could also potentially provide additional support around coordinating access to treatment, and providing psychosocial supports and coaching services. In the Frail Elder Waiver (HCBS) MA Health includes a service " Supportive Home Care Aide", which is a home health aide with specialized training in behavioral health management or Alzheimer's/dementia. The MFP-residential (Money Follows the Person) supports and MFP-community-living waivers operate concurrently with a managed behavioral health component, i.e., participants in these two waivers are enrolled in MBHP which manages their behavioral health services.

Training for HCBS providers can help them to recognize and be as responsive as possible to the needs of people with behavioral health concerns. These are important long-term goals to ensure that people with behavioral health conditions are supported in the community whenever possible.